# KeyData User Manual – NEMSIS V3.3.4 Edition
## Version 1.01:  7 November 2016

KeyData is software for creating prehospital patient care reports, printing or saving them for local use, and uploading the data they contain to the State of Illinois.  The KeyData installation program is currently available to all EMS agencies licensed as transport vehicle providers by the State of Illinois, and is free of charge.  This manual provides step-by-step guidance for accessing the installed application and using it to create patient care reports and perform other basic tasks.  A separate manual is available for System Administrators.

## Contents

## Prerequisites

1.  Your agency's KeyData System Administrator has loaded the KeyData application onto your computer and the following icon appears on your desktop:



2.  You have been assigned a user name and password.

3.  Your KeyData System Administrator (or other designated person) has pre-entered personnel data for all of your agency's employees who will be documented in your patient care reports.

## Opening the Application

1. Double-click the KeyData icon on your computer's desktop.

2. Enter your assigned user name and password into the login screen that appears.

3. Press Enter on your keyboard.  The application's main screen will appear, with your agency's name and city appearing in the lower left-hand corner:
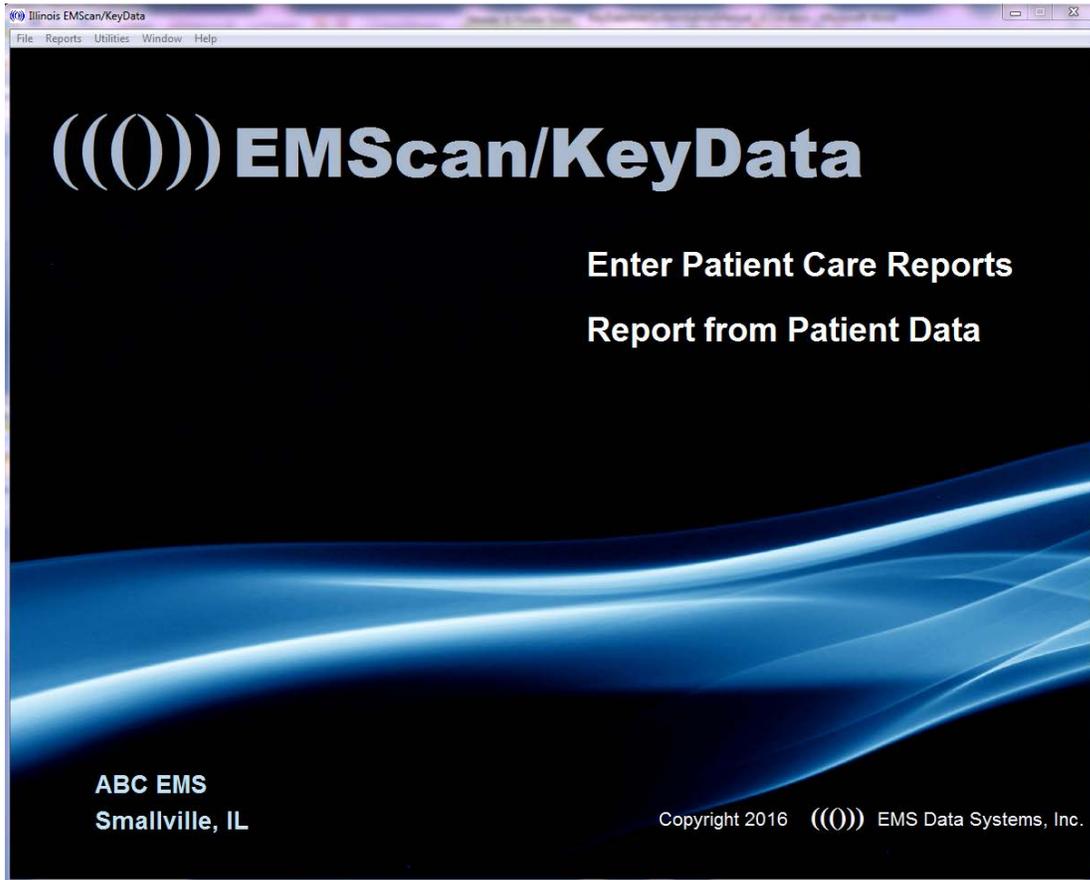


## Accessing the Personnel Data Screen and Checking Personnel Data[1]

1. Select the Enter Personnel Data option from the File dropdown menu:



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[1] Your KeyData Administrator has the ability to disable this feature for non-administrative users.

2. A Personnel Data Entry screen will appear. Using the navigation buttons at the bottom of this screen, advance through the list and make sure that it contains an entry for each crewmember that could appear in a run report. Also verify that the name, ID number (the person's state license number), level, and usual role are correct. If personnel are missing, or if any of the information is incorrect, either contact your System Administrator or add/correct the information yourself, depending on your agency's policy on the entry of personnel data.

## Accessing the Patient Care Report Screen

1. Select the Enter Patient Care Reports option from the File dropdown menu:



2. The Patient Care Reports screen will appear:

Notice that this screen contains:

- Seven tabs at the top, for navigation within each patient care report;
- Five buttons on the bottom left, for navigation among different patient care reports;
- Five buttons on the bottom right, for printing, creating, editing, and deleting patient care reports, and exiting the Patient Care Report screen.

3. The plus and minus buttons at the top of the Patient Care Reports screen allow resizing:
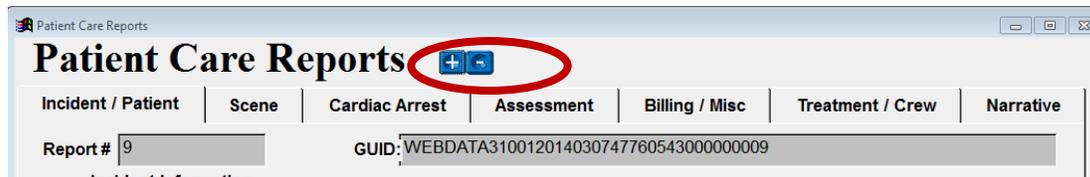


## Entering Information into Patient Care Reports

To open a new patient care report and begin entering information, click on the **New** button at the bottom of the screen.  Unless otherwise noted, complete all information that applies to the patient and incident.  This section of the manual is organized by patient care report tab.

⇨ *Note:  Information entered into green-shaded fields will appear on printed and locally saved reports but is not uploaded to the state.  These fields are not addressed in this manual.*

I. **Incident/Patient tab**

A. **Report/Record Identification Information**

The **Report#** and **GUID** fields at the top of this tab are automatically completed by the system and are for system use only.  No action is needed from the user.

B. **Incident Information**

⇨ ***Note:  If the patient is not transported by your unit then Not Applicable should be selected for the last seven fields included in this section (items 6-12, below).  If the patient is transported by your unit but the destination is not a hospital then Not Applicable should be selected for items 9 & 10.***

1. **Agency:**  Your agency's name will automatically appear in this field.
2. **EMS Sys:**  Select your Resource Hospital/EMS System number from the dropdown list.  If your agency belongs to more than one System, each will appear in the list.
3. **Inc #:**  Enter the number assigned to the incident by the 911 dispatch system.
4. **Resp #:** A unique number assigned by your agency to each EMS unit's response to an incident.
5. **Date:**  If the incident date is today's date, click the Use Today's Date button and the system will fill in the date; otherwise, manually enter the correct incident date.
6. **Outcome:**  Select the outcome of the call from the dropdown list.
7. **Destination:**  If *your unit* transported the patient to a hospital, select that hospital from the dropdown list; otherwise, leave this field blank.

8.  **Type:** Select the type of destination to which *your unit* transported the patient; if Hospital is selected, you must select a hospital in the Destination field; if your unit did not transport the patient, leave this field blank.

9.  **Zip:** This field is completed automatically when a hospital destination is selected. It must be completed manually whenever your unit transports a patient to a non-hospital destination.

10. **Hospital Designation:** Select the primary hospital capability associated with the patient's condition for this transport (e.g. Trauma, STEMI, Stroke, Behavioral Health); select Hospital (General) if no specialty designation applies.

11. **Hospital Inpatient Dest:** If a patient that *your unit* transported to a hospital was delivered directly to an inpatient location by your crew, select that location (e.g. Cath Lab, ICU).

12. **Condition of Pt at Dest:** The patient's condition during *your unit's* handoff at the transport destination.

13. **Dest Reason(s):** If *your unit* transported the patient then check one or more reasons for choosing the destination on the sub-screen that appears when you click on the field.

C.  **Unit Information**

1.  **ID:** Enter the two-digit vehicle identifier for your unit. This is the last two digits of your unit's six-digit license plate number.

2.  **Call Sign:** For use if your agency uses call signs and requires you to enter one, or if your EMS System requires or requests it. An entry is not required by the state.

3.  **Service Requested:** From the dropdown list, select the type of service that your unit was dispatched to perform.

4.  **Primary Role:** From the dropdown list, select the primary role assigned to your unit, regardless of actual call outcome/disposition. In most cases your selection will be Transport, because in Illinois only units licensed as transport vehicles are required to submit run report data to the state.

5.  **First Unit on Scene:** Select Yes if your unit was the first EMS unit from your agency to arrive at the scene and select No if it was not. Select Not Applicable if the call was cancelled while your unit was en route to the scene.

D.  **Dispatched For**

1.  **Complaint:** From the dropdown list, select the primary complaint provided by the 911 dispatcher.

2.  **EMD?:** Indicate the Emergency Medical Dispatching (EMD) status using the dropdown menu.

3.  **Loc. Type:** Choose the value that best describes the kind of location where the incident occurred.

4.  Identify the scene location using the **Address**, **City**, **County**, and **State** and **Zip fields**.

5. **Work Rel?:** Select Yes if the illness or injury that is the reason for the call is work related. If Yes is selected you must also specify the patient's occupation by completing the **Occupation** field in the Patient Information section.

E. **Patient Information**

1. Enter required patient residence location information using the **Addr**, **City**, **County**, **State**, and **Zip** fields.

2. Enter additional patient demographic information using the **Gender, Race,** and **Poss. Pregnant?** dropdown boxes.

3. **DOB:** Enter using a month/day/year format. If you enter only the last two digits of the year, the system will enter the first two. If the patient is 100 years old or older you must manually enter a full four-digit year.

4. **Age:** Age and age units are automatically completed when a date of birth is entered. If the birthdate is unknown then the age and age units must be manually completed; estimate if necessary.

5. **Occupation:** Select the patient's occupation from the drop down list; may be left blank if Yes was not selected for **Work Rel?**.

II. **Scene tab**

A. Record the total number of patients at the scene and whether or not a mass casualty incident (MCI) exists using the **#Pts** and **MCI** dropdown menus. For reporting purposes, an MCI exists when locally available emergency and health care resources, accessed using routine processes, are rendered inadequate due to high patient volume, and non-routine assistance becomes necessary.

B. **Possible Injury?:** Select Yes for either a known injury or a possible injury based on mechanism (mechanism of injury has been variously described as: the way in which the person sustained the injury; how the person was injured; the process by which the injury occurred, or; the events leading to the injury situation).

C. If Yes is selected for **MCI**, select the patient's initial triage status from the **MCI Triage Tag** dropdown menu (certain categories available in the dropdown menu may not apply to the triage system in use at the incident).

D. Click on the **Add/Change Barriers to Care** button, check all items that apply, and then click the save button. If there was no patient, check Not Applicable. If there was a patient but no barriers, check None.

E. Click on the **Add/Change Injury Indicators** button to select and save one or more vehicular, pedestrian, or other injury risk factors from steps 3 and 4 of the Centers for Disease Control Prevention's *Guidelines for the Field Triage of Injured Patients* (criteria from steps 1 and 2 of the *Guidelines* are documented using the **Trauma Center Criteria** field located on the Assessment tab).

F. If Yes was selected for **Injury?**, click the **Add/Change Safety Equipment** button, check all items that apply, and then click the **Save** button on the sub-table.

G. If Yes was selected for **Injury?** and the patient was involved in a motor vehicle crash select her or his location in the vehicle from the **Pt Location** dropdown menu.

H. **LE Crash number:**  Enter the number from the law enforcement crash report if the patient was involved in a motor vehicle crash.

I. Record the presence of drug and/or alcohol use indicators by clicking on the **Add/Change Drug/ETOH Indicators** button, checking all items that apply, and clicking the save button; this field *does not* document that the patient was under the influence of drugs and/or alcohol at the time of the incident, only that one or more of the indicators was noted.

J. **Times:**  Using military (24-hour) format, enter all times that apply to the incident.  Dates will autopopulate based on the report date but should be checked for accuracy and changed as needed.

K. Select the appropriate **Mode To Scene** value from the dropdown list; click on the **Add/Change Response Mode Descriptors** button to record applicable additional details.

L. **EMS Transport Method:**  Select the type of conveyance used to transport the patient.

M. Select the appropriate **Mode From Scene** value from the dropdown list; click on the **Add/Change Transport Mode Descriptors** button to record applicable additional details.

N. Open the **Destination Team Pre-Arrival Activation** sub-screen to record that an activation (or alert) was called in by EMS to the appropriate destination healthcare facility team.

III. **Cardiac Arrest tab**

Select the appropriate Yes value from the **Cardiac Arrest?** dropdown menu to indicate an arrest occurring either before or after the arrival of your unit.  Select Not Applicable if there was no patient and No if there was a patient but no arrest.

⇨ *Note:  The remaining fields on the Cardiac Arrest tab and identified in the manual section should only be completed when **Cardiac Arrest?** equals one of the two Yes values.*

A. **Arrest Time and Date** must always be completed when the arrest occurred after EMS arrival and when the arrest occurred prior to EMS arrival if known.

B. Based on the cardiac-arrest-related observations and activities of your crew, report the following information using the dropdown menus or checkboxes provided: **Etiology**, **Witnessed By**, **First Monitored Rhythm**, **Resuscitation Attempts**, **Type(s) of CPR**, **ROSC**, **Rhythm at Destination**, **Therapeutic Hypothermia Use**, **Reason for Discontinuation of CPR**, and **End of EMS Cardiac Arrest Event**.

C. Complete the **CPR Provided Prior to EMS Arrival?** and **User(s) of AED Prior to EMS Arrival?** fields; identify the provider types if the response for either is Yes.

IV. **Assessment tab**

A. **Weight:**  May be entered for all patients, but required for patients younger than 16; provide an estimate if the actual weight is unknown; use kilograms (1 kg = 2.2 lbs; 1 lb = 0.454 kg).

B. **Broselow Color:**  The color-coded Broselow Tape is used for pediatric patients and relates a child's height as measured by the tape to his/her weight to provide medical instructions including medication dosages, the size of the equipment that should be used, and the level of shock voltage when using a defibrillator.   Select the correct color from the dropdown list if applicable and available.

C. **Initial Pt Acuity**:  Select the acuity value that best reflects the patient's condition upon EMS arrival at the scene.

D. Select the **Primary Symptom** from the dropdown list and use **Add** button for **Other Associated Symptoms** to document any additional symptoms.

E. Select the **Impression** from the dropdown list and use the Add button under the **Secondary Impressions** field to indicate your impression of the primary and secondary problems/conditions leading to the medications, procedures, and/or other types of treatment given to the patient.

F. Click on the **Add/Change Skin Assessments** button to select one or more descriptors for characterizing the patient's skin condition.

G. **Cause of Injury:**  If Yes was selected for **Injury?** select the cause(s) from the dropdown list.

H. Click on the **Add/Change Trauma Center Criteria** button to select and save one or more physiologic and/or anatomic field trauma triage criteria from steps 1 and 2 of the Centers for Disease Control Prevention's *Guidelines for the Field Triage of Injured Patients* (risk factors from steps 3 and 4 of the *Guidelines* are documented using the **Injury Indicators** field located on the Scene tab).

I. **Complaint Anatomic Location:**  Select the *primary* anatomic location associated with your primary impression of the patient's chief complaint**.**

J. **Complaint Organ System**:  Select the *primary* anatomic organ system location associated with your primary impression of the patient's chief complaint.

K. Click the Add button under the **Medical/Surgical History** field and use the drop menus to record up to ten items.

L. To create a vitals set click the **Add** button below the **Vital Signs** table and then complete and save the Vitals Set Entry sub-screen that appears.  Repeat this process to create as many additional sets as needed.  Use the **Change** or **Delete** buttons to change or delete an existing set.

V. **Billing / Misc tab**

⇨ *Note:  Your entries in the **CMS Service Level, Condition Codes,** and **Primary Method of Payment** fields may be updated later by your agency's billing department.*

A. **CMS Service Level:**  Select the medically necessary Centers for Medicare & Medicaid Services (CMS) level of treatment provided to the patient.  For more information about CMS Service Levels, including definitions, see *Medicare Benefit Policy Manual, Chapter 10—Ambulance Services, Sub-section 30.1—Categories of Ambulance Services* (accessed at http://www.cms.hhs.gov/manuals/Downloads/bp102c10.pdf on 20 June 2009).

B. Click the **Add/Change Condition Codes** button, select all items that apply, and then click on the **Save** button. Used to communicate the patient's condition (as observed by the ambulance crew) to a Medicare contractor or other billing oversight authority.

C. **Primary Method of Payment:**  Select the appropriate choice from the dropdown list if known.

D. **ED Disp** and **Hosp Disp:**  Select the appropriate choice from each of these dropdown lists.

E. Odometer readings are for your agency's use only, and are not required by the state.

F. Document any delays by clicking the **Add/Change Delays** button, selecting all that apply in each of the five categories, and saving your selections. A delay should only be recorded for unusual circumstances and when there is a meaningful loss of time associated with those circumstances, based on the judgment of the EMS crewmember completing the report.

G. **Receipt Confirmed by State:** When checked, this checkbox indicates that the state has received the run report.

VI. **Treatment / Crew tab**

A. Record each medication administered to the patient by clicking the **Add** button under the **Medication** table, entering the date and time, and using the dropdowns to select the medication name, administration route, dosage and dosage units, authorization type, patient response, and the role or type of the administering person (if KVO/TKO is selected for Units then Dosage should be left blank). For each medication entered you must also click on the **Update List** button under the **Complications** table and complete and save the Medication Complications sub-screen that appears. At least one box on the Complications screen must be checked (if there were no complications associated with a medication then select None). You may change or delete saved a medication screen by clicking on the medication name in the main table and then clicking the **Change** or **Delete** button.

B. Record each procedure performed on the patient by clicking the **Add** button under the **Procedure** table, entering the date and time, and using the dropdowns to select the procedure name, of attempts, success status, authorization type, patient response, and the role or type of the person performing the procedure. For each procedure entered you must also click on the **Update List** button under the **Complications** table and complete and save the Procedure Complications sub-screen that appears. At least one box on the Complications screen must be checked (if there were no complications associated with a procedure then select None). You may change or delete **a** saved procedure screen by clicking on the procedure name in the main table and then clicking the **Change** or **Delete** button.

C. Click on the **Add** button under the **Protocols Used** table to document the protocol name and patient age range for each protocol used in the course of providing care to this patient.

D. Open the **Exposure/Precautions** screen by clicking on the **Add** button and document PPE usage for each crewmember. Also document exposure/injury/death for each crewmember, when applicable. Click on an entry in the main table and then click the **Change** or **Delete** button to change or delete the row containing that entry.

E. Crewmember information:

1. Click the **Add** button under the **Crewmember** table to display the **Add Crewmembers** screen.

2. Select your crew's crewmembers from the dropdown lists. As noted in the section of this manual that describes how to check/add personnel data, crewmembers must be

added to the system *before* attempting to create a patient care report.  A crewmember's name, default role, level, and ID number will automatically be pulled into the patient care report, using the information entered when her or his personnel screen was created.  Of these items, only Role may be changed within the patient care report, because a crewmember may serve in one or more roles other than his or her default role – modify the role as needed.

3. Select each item of personal protective equipment worn by each crewmember from the dropdown lists.

4. Document whether or not there was a known or suspected exposure or injury, and if there was, select the type(s).

5. Click the save button to display the updated information on the Treatment Crew tab.

To edit previously saved crewmember information, click on the crewmember's row and then click **Change** to display an **Update Crewmember** table.  Click **Save** after editing is complete to display the updated information on the Treatment / Crew tab.

To delete a crewmember from the table, click on that crewmember's row and then click the Delete button.

**VII.    Narrative tab**

Complete the narrative tab as directed by your agency.  Narrative information is for local use only and is not sent to the state.


## Error-checking and Saving Completed Patient Care Reports, Saving Partial Reports, and Editing or Deleting Saved Reports

1. After entering all pertinent information into a report click on the **Save** button at the bottom of the screen.  If any field contains an invalid entry an error message will be displayed in red at the bottom of the screen.  If there is more than one error only one error message will be displayed at a time.  Click repeatedly on the **>** symbol immediately to the right of the error message currently displayed to scroll through any remaining error messages.  Whenever you scroll to a new error message the screen will take you to the tab and field containing the error identified in that message.

2. Correct each error and then click the **Save** button again.  Once all errors are successfully corrected then no error messages will appear, the data entry boxes will change color, and the screens will no longer be editable.  Your report is complete.  If all errors were not corrected then one or more error messages will again appear.  Correct these and click the **Save** button again, repeating the process until all errors have been eliminated and the system allows you to save the completed patient care report.

3. To change information in a completed report, locate the report using the navigation tools described in the next section of the manual and then click the **Edit** button at the bottom of the screen.  The report will go to an edit mode.  After completing the changes save the edited report using steps 1 and 2, above.

4.  To save a partially completed patient care report incomplete to work on later, click the **Save** button and then click the **Partial** button.  The following message will appear:



Click **OK**.  The data entry boxes will change color, the screens will no longer be editable, and the word **INCOMPLETE** will display in the upper right-hand corner of the report in red boldface capital letters.  To resume work on a partially completed report access that report and click the **Edit** button.  Remember to save the report once you have finished editing it.

5.  If you make changes to a saved report that you opened using the **Edit** button and wish to eliminate those changes, click on the **Revert** button.  The report will exit the edit mode and return to the last saved version of the report.

6.  Click the **Delete** button at the bottom of the screen to delete a completed patient care report.

## Navigating Among Completed Patient Care Reports

Use the five buttons on the bottom left-hand side of the Patient Care Reports screen to navigate among the different patient care reports that you have saved to your computer:

- **Top:** Displays the first report in the system
- **Prev:** Displays the report that is immediately before the report currently displayed
- **Next:** Displays the report that is immediately after the report currently displayed
- **Bottom:** Displays the last report in the system
- **Find:** Displays a **Search** screen that can be used to locate specific reports

## Printing Patient Care Reports

Completed or partially-completed patient care reports may be sent to a printer or PDF file:

1.  If the report that you wish to print is not currently displayed on your screen, access it using the navigation tools described in the previous section of the manual.

2.  Click the **Print** button at the bottom of the screen.  The following subscreen will appear:
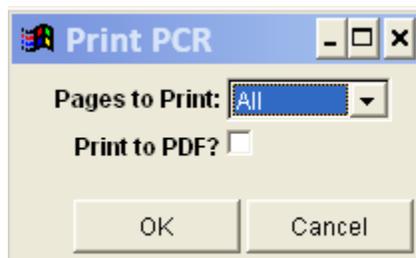
3.  Use the **Pages to Print** dropdown menu to select the pages of the report that you wish to print.  The default selection is all pages.

4.  To print a paper copy of the report, ensure that the **Print to PDF?** checkbox is unchecked and click the **OK** button.  The report will print to your default printer.

5.  To print the report to a PDF file, ensure that the **Print to PDF?** checkbox is checked and click the **OK** button.  A **Save As** screen will appear.  Specify a name and location for the PDF file and then click the **Save** button.

## Confidentiality

Patient care reports contain confidential information.  Ensure that you are familiar with and follow all federal and state laws and regulations as well as your agency's policies when saving, printing, transporting, and transmitting paper and electronic versions of the patient care reports that you create using this application.

## Uploading Your Patient Care Report Data to the State Database and Downloading Software Updates

Once a Patient Care Report has been completed and saved it is automatically uploaded to a database maintained by the State of Illinois whenever an Internet connection to your hardware has been detected.  With hardware that is always connected to the Internet, this happens as soon as a completed report is saved (partial reports are not uploaded). With hardware that is only sometimes connected to the Internet, all data that has not been previously uploaded will upload automatically whenever the next Internet connection occurs.  Software updates will automatically download when a user opens the KeyData application on a computer connected to the Internet, and they will become active the next time the application is opened.  Regular connection to the Internet with the KeyData application open and logged into is required and at least one connected session per day is recommended to ensure that your agency's patient care reports are transmitted to the state in a timely manner and that your software is kept up to date.

## Changing Your Password and Other Utilities Options

1.  You must be logged in to the system to change your password.

2.  Select the New Password Entry option from the Utilities dropdown menu:



3.  A Change Password screen will appear.  Enter and confirm your new password in the boxes provided and then click OK.

4.  Do not attempt to use any of the other Utilities options unless instructed to do so by your System Administrator.

## Summary Reports

Two summary reports may be accessed from the Reports dropdown menu:

- The **Audit Report** displays the number of completed and incomplete reports that you entered, by month and year.

- The **Incident Location and Type** report displays the number and percentage of calls by incident location category and type of call, for the reports that you entered.

## Assistance

If you have questions about this application or are having problems using it contact your agency's KeyData System Administrator, IT department, or other designated point of contact.